EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED: Your employer is insured by

Insurer ______________________________

Street and Number ______________________________

City ______________ State ______________ Zip Code ______________

For the period from ______________ Through ______________

Adjusting Company ______________________________

Street and Number ______________________________

City ______________ State ______________ Zip Code ______________

Telephone ______________________________

This insurance pays benefits for job-connected injuries, illnesses or death as provided by the Alaska Workers' Compensation Act

Employer ______________________________

By ______________________________

Title ______________________________

Witness ______________________________

Witness ______________________________

Immediately (not later than 30 days from injury or death date) give your employer and the Alaska Workers' Compensation Division written notice of a job-related injury, illness, or death. Get the "Report of Occupational Injury or Illness" form from your employer for this purpose. If you have questions about your rights or benefits under the Alaska Workers' Compensation Act, contact the insurer at the above address and the Alaska Workers' Compensation Division at the nearest office listed below:

ANCHORAGE	FAIRBANKS	JUNEAU
3301 Eagle Street	675 7th Avenue	PO Box 115512
Suite 304	Station K	1111 W 8th St Room 305
Anchorage, AK 99503	Fairbanks, AK 99701-4586	Juneau, AK 99811-5512
(907) 269-4980	(907) 451-2889	(907) 465-2790

NOTICE TO EMPLOYER: AS 23.30.060 requires that you post this notice in three conspicuous places on the employer's premises.

Form 07-6120 (Rev 05/2012)

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